Supreme Court, U.S.
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No. _____

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1993

HERMAN E. MITCHELL,
Petitioner,

v.

ALLSTATE LIFE INSURANCE COMPANY,
NORTHBROOK, ILLINOIS, et al,
Respondents.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF
APPEALS FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Did the District Court, and the Fifth Circuit in affirming the District Court, apply the wrong standard of review in applying an "arbitrary, made without rational basis, nor clearly erroneous" standard instead of the "*de novo*" standard of review delineated by this Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) for a denial of ERISA benefits under 29 U.S.C. § 1132(a)(1)(B) (1994)?

2. Did the District Court and the Fifth Circuit in affirming the District Court, erroneously limit evidence in a "*de novo*" review to only that evidence that the ERISA plan administrator testified was in the ERISA plan administrator's physical file at the time of the denial of disability

benefits?

3. Was Petitioner Herman E. Mitchell's disability claim denial by Metropolitan Life Insurance Company afforded a "full and fair review" as required by 29 U.S.C. § 1133 (1994) and 29 C.F.R. § 2560.503-3(f) (1993) and did Metropolitan breach its fiduciary obligations pursuant to 29 U.S.C. § 1132(a)(3) (1994)?

4. Did the fact that the ERISA plan administrator failed to provide the statutorily mandated ERISA notice to Petitioner deprive Petitioner of Petitioner's right to substantive and/or procedural due process?

PARTIES

The Petitioner is Herman E. Mitchell, Plaintiff and Appellant in the underlying action.

The Respondents are Metropolitan Life Insurance Company (herein sometimes called "Metropolitan") and Allstate Life Insurance Company, Northbrook, Illinois, (herein sometimes called "Allstate") Defendants and Appellees in the underlying action.

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OPINIONS BELOW

The "Judgment" and "Findings of Fact And Conclusions of Law" of United States District Judge Paul Brown Signed January 6, 1993, is appended hereto (App. 1 - 10).

The "Order" of United States District Judge Paul Brown signed May 27, 1993 denying petitioner's motion for a new trial is appended hereto (App. 11 - 20).

The opinion of the United States Court of Appeals For The Fifth Circuit captioned "Herman E. Mitchell v. Allstate Life Insurance Company, et al., (case number 93-4991)", affirming the district court is appended hereto (App. 21 - 22).

JURISDICTION

The United States Court of Appeals for the Fifth Circuit issued its opinion affirming the United States District Court judgment on March 3, 1994.

No rehearing was requested, and no extension of time was requested.

28 U.S.C. § 1254(1) confers jurisdiction upon the Supreme Court of the United States in this matter.

CONSTITUTIONAL PROVISIONS

U.S. CONST. amend. V

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

U.S. CONST. amend. XIV, § 1

> All persons born or naturalized in the United States, and subject TO the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

STATUTES

29 U.S.C. § 1132(a)(1)(B) (1994)

(a) Persons empowered to bring a civil action. A civil action may be brought --

> (1) by a participant or beneficiary -- (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. § 1132(a)(3) (1994)

(a) A civil action may be brought --

> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

29 U.S.C. § 1133 (1994)

In accordance with regulations of the Secretary, every employee benefit plan shall --

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 C.F.R. § 2560.503-1(f)

(f) *Content of notice.* A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an

explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

STATEMENT OF THE CASE

A. PROCEEDINGS BELOW

Jurisdiction was vested in the United States District Court pursuant to the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. The Appeal in the Fifth Circuit Court of Appeals was an appeal from a final judgment of the United States District Court in a civil case brought pursuant to ERISA. Petitioner timely filed a notice of appeal with the Fifth Circuit Court of Appeals. The Fifth Circuit Court of Appeals had jurisdiction over the appeal from the final judgment of the District Court under 28 U.S.C. § 1291 (1982). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1) (1982).

This action was originally filed in the Texas State District Court by Petitioner, as plaintiff, and then removed to United States District Court for the Eastern District of Texas, Sherman Division by the defendants. Respondents herein are the Defendants, Metropolitan and Allstate.

Petitioner brought this suit to recover benefits under an insurance policy that was issued to Petitioner's employer to provide the employees with disability coverage (herein called the "ERISA plan"). The disability insurance coverage is an employee benefit regulated by ERISA.

ERISA provides Petitioner a cause of action under 29 U.S.C. § 1132(a)(1)(B) (1994) to recover benefits under the ERISA plan and under 29 U.S.C. § 1132(a)(3) (1994) for

breach of fiduciary duty. Further, 29 U.S.C. § 1133 (1994) provides that Petitioner is to be provided with a "full and fair review" of Petitioner's claim denial.

B. KEY FACTS

On June 20, 1989, Petitioner filed his application for disability benefits. The injury underlying Petitioner's claim was "niacin maculopathy with nonstaining cystoid macular edema" (permanent scar tissue on the inside of the eyeballs resulting from the ingestion of niacin). The niacin was prescribed for high cholesterol by the doctor conducting Petitioner's annual company physical. Petitioner's application for disability contained a two page job description of Petitioner's job, "Vice President of Administration, (Chief Financial

Officer)." Petitioner's application also set forth that Petitioner is a certified public accountant with a masters degree in business administration.

On August 11, 1989, Metropolitan denied Petitioner's claim for benefits referring to the incorrect ERISA plan definition of "total disability."

On August 18, 1989, Petitioner requested a review of his claim. On August 23, 1989, Metropolitan again denied Petitioner's claim, but admitted that Metropolitan had applied the incorrect definition of "total disability."

On September 25, 1989, Petitioner again requested that Metropolitan review Petitioner's claim and submitted a letter dated September 19, 1989 from Petitioner's employer verifying that

Petitioner's job performance had declined since Petitioner's injury (May, 1987).

On October 10, 1989, Metropolitan again denied Petitioner's claim and incorrectly stated that Petitioner's job performance declined over a ten (10) year period, when Petitioner's employer verified that Petitioner's job performance had declined since the injury (May 1987), or a two (2) year period.

On November 2, 1989, Petitioner again requested a review of his claim. On November 8, 1989, Metropolitan again denied Petitioner's claim but stated, "We would be happy to reopen Mr. Mitchell's claim for further evaluation upon receipt of objective medical evidence..."

In an attempt to obtain the "objective medical evidence" requested by Metropolitan, Petitioner had a battery of physical medical tests performed on his eyes on January 9, 1990 by Petitioner's eye specialist, Dr. Fuller.

This battery of medical tests included: (1) fundus examination of the right eye; (2) fundus examination of the left eye; (3) a fluorescein angiography being performed on the right eye; (4) a fluorescein angiography being performed on the left eye; (5) a focal electroretinography being performed on the right eye; and, (6) a focal electroretinography being performed on the left eye (herein together called the "January 1990 Medical Tests").

On January 15, 1990, Petitioner's attorney submitted to Metropolitan Dr. Fuller's medical report dated January 11, 1990, which detailed the January 1990 Medical Tests. Based on the January 1990 Medical Tests, Dr. Fuller's medical report specifically verified a "*permanent visual compromise*" to Petitioner resulting from Petitioner's injury and specifically verified that "*Mr. Mitchell particularly has difficulty with prolonged reading of small print,*" (emphasis added).

During this litigation Petitioner also obtained affidavits from Petitioner's other two treating physicians, Dr. Louis Shirley (Petitioner's long standing eye doctor) and Dr. Keller Greenfield (the doctor who originally prescribed the niacin),

specifically stating and verifying that Petitioner *was disabled*. (Emphasis added.)

Both doctors reached this decision upon reviewing: (1) the results of the January 1990 Medical Tests; (2) Petitioner's correct job title within his company; (3) Petitioner's correct job description; and, (4) the correct definition of the term "total disability" as defined under the ERISA plan. (App. 23 - 36). Both doctors were timely and properly listed with the District Court as expert witnesses.

On January 24, 1990, Metropolitan confirmed the reopening of Petitioner's claim and advised Petitioner's attorney that Metropolitan had received the January 11, 1990 medical report of Dr. Fuller.

Further, on January 24, 1990, Metropolitan's claim administrator's immediate supervisor specifically instructed (in writing) to have Metropolitan's medical consultant look at the medical, including Dr. Fuller's January 11, 1990 medical report which detailed the January 1990 Medical Tests. In direct response to this, Metropolitan purportedly sent certain information to Metropolitan's medical consultant for review (paying the consultant a $195 fee for this review).

Metropolitan's medical consultant issued a report that was prepared: (1) without Metropolitan's medical consultant speaking with or examining Petitioner; (2) without Metropolitan's medical consultant speaking with any of Petitioner's three treating physicians; and (3) without considering the results

of the January 1990 Medical Tests.

It was this report of Metropolitan's medical consultant dated January 30, 1990 upon which Metropolitan relied in denying Petitioner's claim on February 2, 1990.

However, it was, and is uncontroverted that *the report of Metropolitan's medical consultant did not consider the January 11, 1990 medical report relating to Petitioner's January 9, 1990 medical examination and the January 1990 Medical Tests* (emphasis added).

Metropolitan's claim administrator did not notice this discrepancy until her March 28, 1991 deposition and had no explanation as to why Metropolitan's medical consultant did not consider Dr. Fuller's January 11, 1990 medical report or why she did not notice the

discrepancy when the report of Metropolitan's medical consultant was originally received by Metropolitan on February 2, 1990.

The medical report of Metropolitan's medical consultant specifically stated on its face that the records considered as a basis for the report only included those in which the "Petitioner *was last seen on June 20, 1989*," (emphasis added). Metropolitan's medical consultant did not consider the results of any of the January 1990 Medical Tests. Dr. Fuller's January 11, 1990 report was based on Petitioner's January 9, 1990 physical examination.

By letter dated February 2, 1990, Metropolitan denied Petitioner's claim and: (1) did not state that any additional information could be

submitted to Metropolitan; (2) did not identify what evidence had been considered by Metropolitan; and, (3) did not give Petitioner the right to review and rebut any evidence as required by law. In fact, it was not until September of 1990 that Petitioner was provided with a copy of Metropolitan's medical consultant's January 30, 1990 report upon which the February 2, 1990 denial was based.

Further, unknown to Petitioner at the time of the final denial, Metropolitan was erroneously interpreting the word "each" in the ERISA plan definition of "total disability" to mean that if Petitioner had ten material duties to his job and Petitioner could perform only one of those duties, but Petitioner could not perform the other nine duties,

Petitioner was not totally disabled pursuant to the ERISA plan as interpreted by Metropolitan. Metropolitan did not advise petitioner of this fact until March of 1991 in depositions.

C. SUMMARY OF ARGUMENT

First: the District Court and the Fifth Circuit reviewed the ERISA plan term interpretation under an "abuse of discretion" standard instead of a "*de novo*" standard as required by this Court in *Firestone*, 489 U.S. 101, 115 (1989). This "abuse of discretion" standard of review was used after the District Court had previously correctly held that under *Firestone* Petitioner's claim should be reviewed under the "*de novo*" standard.

Specifically, in Conclusion of Law Number 3 the District Court

specifically held that "In this case, the Plan does not confer discretionary authority, and this Court should review plan interpretations *de novo*." (App. 9).

However the District Court and the Fifth Circuit then used the "abuse of discretion" standard and based this distinction on the 1991 Fifth Circuit case *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991), *cert. denied*, 112 S. Ct. 953 (1991).

The Fifth Circuit *Pierre* opinion misquoted this Court's *Firestone* opinion. Furthermore, the Fifth Circuit's *Pierre* opinion is in direct conflict with other Circuit Courts of Appeal on the issue of the proper standard of review for a denial of ERISA benefits under 29 U.S.C. §

1132(a)(1)(B). *See Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991); *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210, 1213-1214 (4th Cir. 1990). *See also Petrilli v. Drechsel*, 910 F.2d 1441, 1446 (7th Cir. 1990) (dicta).

In *Pierre* Justice White, joined with Justice Blackmun, in 1991 dissenting to the denial of certiorari noted:

> Since our decision in *Bruch*, a disagreement has developed in the Courts of Appeals concerning the standard of review to be applied when a benefits decision turns on the facts of the case, rather than the interpretation of the terms in the ERISA plan. The Third and Fourth Circuits have held that a decision of a plan administrator should be reviewed *de novo* (citations omitted). However, in the present case, the Fifth Circuit ruled that an abuse of discretion standard should

> be applied. (citation omitted).
>
> I would grant certiorari to resolve the conflict in the Courts of Appeals on this important issue.

Pierre, 112 S.Ct. at 453. *See also*, *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991) criticizing *Pierre*; and, *Donaldson v. Metropolitan Life Ins. Co.*, 812 F. Supp. 103, 105 (E.D. Mich. 1993) criticizing *Pierre*.

Further, Petitioner would urge that since Justice White and Justice Blackmun's *Pierre* dissent in 1991 the issue to resolve the conflict between the Courts of Appeals is now of even greater importance due to the proposed impending changes in the health care system of the United States.

Second, at trial although the District Court in name held that a "*de*

novo" review was being given, Petitioner was not allowed to present any evidence which was not in Metropolitan's file at the time of the final denial of Petitioner's claim. This is not only contrary to this Court's *Firestone* opinion, but is also contrary to and in direct conflict with the treatment of the issue in other United States Circuit Courts of Appeal (Second, Third and Eleventh Circuits) while being consistent with the Sixth Circuit.

In particular in addressing the same issue the Third Circuit has held that "a district court exercising *de novo* review over an ERISA determination between beneficiary claimants is not limited to the evidence before the Fund's Administrator." *Luby v. Teamsters Health, Welfare & Pension*

Trust Funds, 944 F.2d 1176, 1184-1185 (3d Cir. 1991).

The Eleventh Circuit has held that: "American Home's contention that a court conducting a de novo [sic] review must examine only such facts as were available to the plan administrator at the time of the benefits denial is contrary to the concept of a de novo [sic] review." *Moon v. American Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir. 1989). *See also Masella v. Blue Cross & Blue Shield of Conn.*, 936 F.2d 98, 104-105 (2nd Cir. 1991); *But see Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993); *Perry v. Simplicity Engineering*, 900 F.2d 963, 966-967 (6th Cir. 1990).

Third, the Record shows that Metropolitan did not give Petitioner's

claim denial a "full and fair review" as mandated by 29 U.S.C. § 1133; *Firestone*, 489 U.S. at 113; and, in line with Metropolitan's own claims handling guidelines. This also breached the fiduciary obligations of Metropolitan pursuant to 29 U.S.C. § 1132(a)(3).

Fourth, Metropolitan denied Petitioner of his right to procedural and substantive due process: (1) by failing to provide the notice required by 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1(f) (1991) in the denial letters of Petitioner's claim; (2) by limiting the evidence to only the evidence that was in Metropolitan's file at the time of the denial of Plaintiff's claim; and/or, (3) applying an "abuse of discretion" (or an "arbitrary and capricious" as

specifically used by the District Court) standard of review instead of a "*de novo*" standard of review.

D. REASONS FOR GRANTING PETITION

The issues presented by this petition for certiorari are of great import due to the proposed impending change in the health care system of the United States.

Without a clarification from this Court concerning the: (1) standard of review for ERISA plan "term interpretations" and "factual determinations"; (2) limitation of evidence issue in a *de novo* review; and, (3) resolution of what constitutes a full and fair review, ERISA benefit providers will strive to have their claims heard in the Fifth and Sixth Circuits while ERISA benefit recipients will strive to have their claims heard

in the Second, Third, Fourth, Seventh, Ninth and Eleventh Circuits. The discrepancy between the Circuits will only tend to encourage litigation as in any particular claim there is legal authority on both sides. This is further contrary to the congressional intent of ERISA which is to promote the interests of employees and their beneficiaries.

ARGUMENT

I. DE NOVO REVIEW

In 1989, this Court changed the standard of review from "arbitrary and capricious" to "*de novo*" for cases involving denial of benefits under ERISA. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Justice O'Connor writing for this Court specifically held that

> As this case aptly demonstrates, *the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue.* Consistent with established principles of trust law, we hold tnat a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* [sic] standard ... *Id.* at 115. (Emphasis added).

Based on the foregoing, the District Court in Conclusion of Law Number 3 held that the proper standard of review for Petitioner's case was "*de novo*". (App. 8 -9).

However, the District Court applied the Fifth Circuit's opinion in *Pierre v. Connecticut General Life Ins. Co.*, 932 F.2d 1552, 1562 (5th Cir.), *cert. denied*, 112 S. Ct. 453 (1991), and found that there is a distinction between ERISA plan "term interpretations" and "factual

determinations". The Fifth Circuit in *Pierre* based the distinction between ERISA plan "term interpretations" and "factual determinations" upon the actual language used by this Court in *Firestone*, 489 U.S. at 108 and 115. However, and notably, the Fifth Circuit in *Pierre* misquoted *Firestone* in making this distinction. *Pierre*, 932 F.2d at 1556 provides that:

> The outcome in our case today turns upon the proper application of the Supreme Court's holding in *Bruch*; specifically, we must determine whether *Bruch* encompasses a holding that *de novo* review is required of *factual determinations* by ERISA fiduciaries. In this analysis, a point of tension is created by *Bruch's* express limitation, on the one hand, that, "The discussion that [sic] follows is *limited* to the appropriate standard of review in § 1132(a)(B)(1) [sic] actions challenging denials of benefits based on plan term [sic] interpretations," 109 S. Ct.

> at 953 (emphasis added); and, on the other hand, the absence of the express limitation in the latter part of the opinion: "[T]he validity of a claim to benefits under an ERISA plan is likely to turn on the *interpretation of terms* in the plan at issue."...109 S. Ct. [sic] at 956.

Contrary to the Fifth Circuit's quotation in *Pierre*, this Court in *Firestone*, 109 S. Ct. at 953 actually provides that, "The discussion which follows is limited to the appropriate standard of review in § 1132(a)(1)(B) actions challenging denials of benefits based on plan interpretations." (Emphasis that this Court did not include the word "term" as stated by the Fifth Circuit.)

There is one misquote which is key to the Fifth Circuit's ultimate holding in *Pierre*, and the distinction between "term interpretations" and "factual

determinations". The *Pierre* opinion added and emphasized the word "term" in between the words "plan interpretations". *Pierre*, 932 F.2d at 1556. Without the word "term" inserted, *Firestone* can not be read to make the distinction that the Fifth Circuit in *Pierre*, 932 F.2d at 1556 makes.

Accordingly, the District Court and the Fifth Circuit should not have interpreted *Pierre* to alter the *de novo* standard of review set forth in *Firestone* for the application of Petitioner's case.

This is further supported by this Court in *Firestone* when Justice O'Connor for the Court stated that,

> The discussion which follows is limited to the appropriate standard of review in § 1132(a)(1)(B) actions challenging denials of

> benefits based on plan interpretations. We express no view as to the appropriate standard of review for actions under other remedial provisions of ERISA.

Firestone, 489 U.S. at 108.

Other Circuits have expressly decided not to follow *Pierre* in this distinction between ERISA plan "term interpretations" and "factual determinations." *See Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991); *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210, 1213-1214 (4th Cir. 1990). *See also Petrilli v. Drechsel*, 910 F.2d 1441, 1446 (7th Cir. 1990) (dicta); *Donaldson v. Metropolitan Life Ins. Co.*, 812 F.Supp. 103, 105 (E.D. Mich. 1993).

Thus, the Fifth Circuit's *Pierre* technical reliance on the word "term"

in the above discussed quotation is misplaced when the correct *Firestone* quotation is actually read. In fact, in *Firestone*, 489 U.S. at 108, this Court was not excepting out "factual determinations," but in fact was excepting out sections of ERISA other than the denial of benefits under 29 U.S.C. § 1132(a)(1)(B).

Assuming *arguendo*, that contrary to: (1) *Firestone*; (2) the Third and Fourth Circuits; and (3) the Second Circuit (concerning expert testimony), that factual determinations are to be reviewed under a standard other than "*de novo*," then pursuant to the Fifth Circuit's *Pierre* opinion that standard should be "due deference to . . . factual conclusions that reflect a reasonable and impartial judgment." *Pierre* 932 F.2d at 1562.

To determine whether or not the judgment was impartial, the ERISA plan administrator's inherent conflict of interest and bias must be considered. This consideration is paramount when, as in this case, the ERISA plan administrator, Metropolitan, was the sole entity obligated to pay benefits under the ERISA plan. *Firestone*, 489 U.S. at 115. *Bruch v. Firestone Tire and Rubber Co.*, 828 F. 2d 134, 144 (3d Cir. 1987). *See Lowery v. Bankers Life and Casualty Retirement Plan*, 871 F. 2d. 522, 525 (5th Cir. 1989), *cert. denied*, 110 S. Ct. 152 (1989). As stated by the Eleventh Circuit, "The insurance company here could hardly be regarded as a trustee for an insured." *Moon*, 888 F. 2d at 89.

Finally, (if need be for argument purposes), the District Court did not

apply the standard of review set forth by the Fifth Circuit in *Pierre*. The District Court held in its January 6, 1993 Conclusion of Law Number 6 that the correct standard to apply to factual determinations made by the ERISA administrator was that the determinations were "not arbitrary, made without rational basis, nor clearly erroneous." (App. 10). However, the Fifth Circuit in *Pierre* held that for factual determinations under ERISA plans, "the abuse of discretion standard of review is the appropriate standard; that is, *federal courts owe due deference to an administrator's factual conclusions that reflect a reasonable and impartial judgment.*" (Emphasis added). *Pierre*, 932 F.2d at 1562.

II. LIMITATION OF EVIDENCE IN *DE NOVO* REVIEW

At trial, the District Court erroneously limited the evidence considered to only that evidence which Metropolitan testified existed in Metropolitan's file at the time of the final denial of Petitioner's claim.

Accordingly, relevant medical testimony from Petitioner's treating physicians, Dr. Louis Shirley (Petitioner's long standing eye doctor) and Dr. Keller Greenfield (the doctor who originally prescribed the niacin), specifically stating that Petitioner *was disabled* upon reviewing: (1) the test results of Dr. Fuller's January 1990 Medical Tests; (2) Petitioner's correct job title within his company; (3) Petitioner's correct job description and, (4) the correct

definition of the term "total disability" as defined under the ERISA plan (emphasis added) was not allowed at trial, even though both doctors were timely and properly listed with the District Court as expert witnesses.

Further, as a result of the District Court's ruling at trial, Petitioner was not even allowed to testify as to his own abilities to perform his job. The District Court was very specific at trial in stating on the record:

> So that everyone will understand how I am trying this case, number one, I am going to look at everything that was before the Plan administrator to determine if the administrator abused its discretion in making factual findings with regard to whether or not the claimant was disabled within the meaning of the contract. I have also indicated that I will look at evidence as to whether or not -- I will hear

> evidence as to whether or not there is a valid dispute in the process of processing this claim over interpretation of the terms of the plan. That is the only thing I am going to be looking at. I will let you make your offer of proof, Mr. Kennedy, but I don't think I can try this case *de novo* as to this man's disability.

Clearly the District Court's limitation of evidence was in violation of this Court's holding in *Firestone*, 489 U.S. at 115. *See Luby*, 944 F.2d at 1184-1185; *Moon*, 888 F.2d at 89. *See also Masalla v. Blue Cross & Blue Shield of Conn.*, 936 F.2d 98, 104-105 (2d Cir. 1991). *But see Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993); *Perry v. Simplicity Engineering*, 900 F.2d 963, 966-967 (6th Cir. 1990).

This is especially true since whether or not Petitioner is disabled,

as the term "total disability" is defined in the ERISA plan, is not a "factual determination." It is a "term interpretation."

Metropolitan's ERISA plan administrator testified at her deposition and at trial that she was interpreting the word "each" in the ERISA plan definition of "total disability" to mean that if Petitioner had ten material duties to his job and Petitioner could perform only one of those job duties but Petitioner could not perform the other nine duties, Petitioner was not disabled pursuant to the ERISA plan as interpreted by Metropolitan. However, since the District Court treated this as a "factual determination" it was not reviewed under the "*de novo*" standard, but was reviewed under an "abuse of

discretion" or "arbitrary and capricious" standard.

In particular, the District Court specifically held in Conclusion of Law Number 6 that, "Based upon the evidence before the Plan Administrator on February 2, 1990, the finding that Plaintiff was not totally disabled was not arbitrary, made without rational basis nor clearly erroneous. Such factual determinations did not constitute an abuse of discretion." (App. 10).

In the Fifth Circuit, district courts may consider general principles of common law or state law in resolving issues arising under an ERISA plan which ERISA does not specifically address. *Southern Farm*, 993 F.2d 98, 102-104 (5th Cir. 1993).

Metropolitan's interpretation of the word "each" is contrary to Texas law. Under Texas law, insurers can not propose narrow interpretations of insurance policy language. Insurers can not require the insured to be disabled for *all* of the duties of his occupation to be eligible to recover benefits under the insurance policy. Insurers cannot restrict disability payments if the insured could perform even one of the duties of his occupation. Such an interpretation by insurers has been consistently rejected by the Texas Supreme Court. *Gulf States Underwriters of Louisiana, Inc. v. Wilson,* 753 S.W.2d 422, 427 (Tex. App. -- Beaumont 1988 writ denied); *Prudential Ins. Co. of America v. Tate,* 347 S.W.2d 556, 557-558 (Tex. 1961).

Applying Metropolitan's erroneous interpretation of the ERISA plan to an injury under 29 U.S.C. § 1132 (a)(1)(B), yields ridiculous results. To use the interpretation of Respondents for the ERISA definition, if Petitioner were blind and had both arms and both legs amputated (where he could not see or write or operate a computer or any machine) but he could listen and speak, and that four hours out of every forty hour work week were spent solely listening on conference telephone calls to weekly update meetings from subordinates using only his ears and mouth (while the other 36 hours per week were previously spent using his eyes and hands to perform his other duties) then Petitioner would not be disabled under Metropolitan's interpretation of the terms of the

ERISA plan. However, since the District Court did not find that Metropolitan's interpretation was "arbitrary and capricious", Metropolitan's claim denial and erroneous interpretation was allowed to stand.

This is blatantly inconsistent with this Court's *Firestone* opinion which provides that:

> ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans," (citation omitted)...See generally 29 U.S.C. § 1001 (setting forth congressional findings and declarations of policy regarding ERISA). Adopting Firestone's reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.

Firestone, 489 U.S. at 113-114.

Adopting Metropolitan's interpretation of the ERISA plan in this case would likewise impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted, in contravention to the Congressional intent of ERISA.

If not for the limitation of evidence and "arbitrary and capricious" standard of review used by the District court for perceived "factual determinations," Petitioner's two treating physicians would have been allowed to testify as to Petitioner's disability. [They both had previously sworn in affidavits filed with the District Court that Petitioner *was disabled*. (App. 23 - 36).] Both doctors were also timely and properly listed as petitioner's expert

witnesses. However because of the limitation of evidence and "arbitrary and capricious" standard, the District Court would not consider any evidence that was not in Metropolitan's physical file when Petitioner's claim was denied.

III. FULL AND FAIR REVIEW

29 U.S.C. § 1133 (1994) provides that an ERISA plan administrator is required to provide a claimant under an ERISA plan a "full and fair review" of a claim denial. This Court has also held that a "full and fair review" by the ERISA plan administrator is required. *See Firestone*, 489 U.S. at 113.

Petitioner provided Metropolitan with a letter from Petitioner's employer verifying that since Petitioner's injury (May 1987),

Petitioner's job performance had declined from Petitioner's job performance over the ten years previous to Petitioner's injury.

However, Metropolitan: (1) did not consider this letter in making the decision to deny benefits; (2) did not contact Petitioner's employer to confirm or investigate further Petitioner's employer's statement; and/or, (3) did not send the letter to Metropolitan's vocational consultant or Metropolitan's medical consultant for consideration.

Metropolitan did not request a medical examination of Petitioner or request that Metropolitan's medical consultant examine or even talk to Petitioner. Metropolitan never questioned Petitioner or anyone else as to the effect of Petitioner's injury on

his maintaining concentrated visual attention to read and comprehend words, language and numerical groupings, despite the fact that Metropolitan recorded in writing in Metropolitan's diary on July 17, 1989 that Petitioner could not do "detailed reading for any length of time."

Based on the "fiduciary duty" and "full and fair review" requirements of 29 U.S.C. §§ 1132(a)(3) and 1133, Metropolitan should have reopened Petitioner's claim once Metropolitan discovered that Metropolitan's medical consultant had not considered Dr. Fuller's January 11, 1990 report and the results from Dr. Fuller's January 1990 Medical Tests.

Further, Metropolitan's notice dated February 2, 1990 did not contain the requirements set forth in 29 C.F.R.

§ 2560.501-1(f). None of Metropolitan's other notices comply with the requirements set forth in 29 C.F.R. § 2560.501-1(f) as required by 29 U.S.C. § 1133.

The Fifth Circuit has not specifically addressed what the requirements of a "full and fair review" are, and in this case, refused to adopt the requirements of the Third, Seventh and/or Ninth Circuits.

In particular, had the holdings of the Third Circuit been applied to the facts of this case, Petitioner would have prevailed on the "full and fair review" issue because Metropolitan: (1) did not have substantial evidence to support Petitioner's claim denial; (2) did not provide the specific reasons for denial in any of the denial notices; and, (3) did not inform

Petitioner as to what evidence was relied upon or provide Petitioner with the opportunity to examine the evidence and submit written comments or rebuttal documentary evidence. *See Grossmuller v. Int'l. Union, United Auto., Aero,* 715 F.2d 853, 857-858 (3d Cir. 1983); *Halpin v. W. W. Grainger, Inc.*, 962 F.2d 685, 689-691 (7th Cir. 1992). *See also, Groves v. Modified Retirement Plan, Etc.*, 803 F.2d 109, 116-117 (3d Cir. 1986); *White v. Jacobs Engineering Group Long Term Disability Benefit Plan*, 896 F.2d 344, 349-350 (9th Cir. 1989).

Had Metropolitan followed the mandates of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1(f), Petitioner would have been able to point out, among other things, that Metropolitan's medical consultant did not consider

Petitioner's physician's January 11, 1990 report. Petitioner would have been able to submit documentation comparable to that submitted in this case from two of Petitioner's treating physicians.

Documentation that states that Petitioner was disabled based on a review of: (1) the results of Dr. Fuller's January 1990 Medical Tests; (2) the correct job title; (3) the correct job description; and (4) the correct ERISA plan definition of the term "total disability", Petitioner *was disabled* (emphasis added). (App. 23 - 36). Both doctors were timely and properly listed with the District Court as expert witnesses.

Further, during the claim process, Metropolitan never advised Petitioner that the reason Petitioner's claim was denied was due to Metropolitan's

erroneous interpretation of the word "each" in the ERISA plan definition. It was not until the ERISA Plan Administrator's March 28, 1991 deposition in Chicago that this term interpretation was disclosed as the reason for denial of Petitioner's claim.

IV. DUE PROCESS

Petitioner was deprived of his procedural and substantive due process by: (1) the limitation of the evidence allowed at trial to the evidence contained in Metropolitan's file at the time of the final denial of benefits; (2) application of an "abuse of discretion", or "arbitrary and capricious" standard instead of the "*de novo*" standard; and/or, (3) the failure to provide the notice required by 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-

1(f) in the denial letters of Petitioner's claims. This deprivation includes, but is not limited to, Petitioner's right to cross examine witnesses, Petitioner's right to have decisions based on admissible evidence, Petitioner's right to notice, Petitioner's right to a full and fair hearing, and Petitioner's right to a day in court to be heard. U.S. CONST. amend. V; and U.S. CONST. amend. XIV, § 1.

Metropolitan's final decision was issued by letter dated February 2, 1990, however said decision did not contain the statutorily mandated ERISA notice. The statutorily mandated ERISA notice is imperative since Congress included this notice provision to allow ERISA to pass constitutional (due process) scrutiny. *Brown v.*

Retirement Committee of Briggs and Stratton Retirement Plan, 797 F.2d 521, 527-528 (7th Cir. 1986), *cert. denied*, 107 S. Ct. 1311 (1986). *See* 29 U.S.C. § 1133; 20 C.F.R. § 2560.503-1(f) (1991). The foregoing deprived Petitioner of Petitioner's procedural and substantive due process. U.S. CONST. amend. V and U.S. CONST. amend. XIV, § 1.

CONCLUSIONS

The issues presented by this petition for certiorari are of great import due to the proposed impending change in the health care system of the United States.

Without a clarification from this Court concerning the: (1) standard of review for ERISA plan "term interpretations" and "factual determinations"; (2) limitation of

evidence issue in a *de novo* review; and, (3) resolution of what constitutes a full and fair review, ERISA benefit providers will strive to have their claims heard in the Fifth and Sixth Circuits while ERISA benefit recipients will strive to have their claims heard in the Second, Third, Fourth, Seventh, Ninth and Eleventh Circuits. The discrepancy between the Circuits will only tend to encourage litigation as in any particular claim there is legal authority on both sides. This is further contrary to the congressional intent of ERISA which is to promote the interests of employees and their beneficiaries.

Respectfully Submitted By:

_____

Timothy T. Mitchell
Rashti and Mitchell
Attorney at Law
Texas State Bar No. 14223000
Admitted to the U.S. Supreme Court 05-23-94
4422 Ridgeside Drive
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Attorney of Record for Petitioner

APPENDIX

IN THE UNITED STATES DISTRICT Court
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

HERMAN E. MITCHELL, Plaintiff	X X X	
V.	X X	4:90CV125
METROPOLITAN LIFE INSURANCE COMPANY and ALLSTATE LIFE INSURANCE COMPANY Defendants.	X X X X X	

J U D G M E N T

This action came on for trial before the Court, and the issues having been duly tried and the Court having filed its Finding of Fact and Conclusions of Law.

It is ORDERED and ADJUDGED that plaintiff take nothing and that the action be dismissed on the merits.

It is further ORDERED that all costs shall be paid by the party incurring the same.

Signed this 6th day of January, 1993.

/s/ Paul Brown
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT Court
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

HERMAN E. MITCHELL, Plaintiff	X	
V.	X	4:90CV125
METROPOLITAN LIFE INSURANCE COMPANY and ALLSTATE LIFE INSURANCE COMPANY Defendants.	X	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On December 7, 1992, the parties appeared before the Court for a trial of this case, at which time the Court heard evidence and argument of counsel. After carefully reviewing such evidence and argument, as well as all the pleadings in the case, the Court now enters its findings of fact and conclusions of law pursuant to Fed. R. Civ. P. 52. Any finding of fact that constitutes a conclusion of law will be deemed a conclusion of law, and any

conclusion of law that constitutes a finding of fact will be deemed a finding of fact.

FINDINGS OF FACTS

1. Plaintiff Herman Mitchell ("Mitchell") is a resident of Denton County, Texas.

2. Defendant Allstate Life Insurance Company ("Allstate") is an Illinois corporation authorized to do business in Texas. Defendant Metropolitan Life Insurance Company ("Metropolitan") is also an Illinois corporation authorized to do business in Texas.

3. This case involves a claim for disability benefits made by the Plaintiff under a group insurance policy issued by Allstate Life Insurance Company ("Allstate") and administered by Metropolitan Life

Insurance ("Metropolitan"). The policy was issued to Herring Group Insurance Plan (the "Plan"). During the relevant time period, Plaintiff worked for Herring Marathon Group Inc. ("Marathon Group") as the chief financial officer.

4. Plaintiff first sought medical attention for the condition which forms the basis of his claim in May 1987. Plaintiff suffers from blurred vision in his right eye which inhibits to some degree his ability to perform sustained reading of small print.

5. On or about June 20, 1990, Plaintiff filed his application for total disability benefits under the Plan based upon his impaired eyesight. The application did not contain any medical information.

6. The Plan defines "totally disabled" as one who "is completely and continuously unable to do each of the material duties of his job; and requires the regular care and attendance of a physician."

7. After Plaintiff filed his claim, Metropolitan sent questionnaires to Plaintiff's two treating physicians, Dr. Dwain Fuller and Dr. Louis Shirley, but neither doctor indicated that Plaintiff was totally disabled.

8. Based upon this medical information, Metropolitan denied coverage in August 1989.

9. On August 19, 1989, Plaintiff requested a review of the denial. On August 23, 1989, Metropolitan again denied Plaintiff coverage stating that Plaintiff's physicians did not believe that he was totally disabled.

10. On or about January 9, 1990, Plaintiff saw Dr. Fuller and his report was forwarded to Metropolitan. Metropolitan sent Plaintiff's medical information to a Board Certified Specialist and a vocational expert for review regarding Plaintiff's disability. These two consultants also concluded that Plaintiff was not totally disabled. Based upon these reviews, Metropolitan found that plaintiff was not completely and continuously unable to do each of the material duties of his job, did not require the regular care and attendance of a physician, and therefore denied Plaintiff's claim on or about February 2, 1990.

11. The only medical evidence submitted to Metropolitan by Plaintiff prior to Metropolitan's final denial of

his claim was obtained from Drs. Louis Shirley and Dwain Fuller. Neither doctor indicated that Plaintiff was totally disabled.

CONCLUSIONS OF LAW

1. This is an action for benefits under an employee benefits plan within the meaning of the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 - 1461. The plan is regulated and governed exclusively by ERISA.

2. Venue is proper pursuant to 29 U.S.C. § 1132(e)(2).

3. If the language of an ERISA plan is unambiguous, the court should review de novo the relevant language in determining the discretion retained by the plan administrator. If the plan confers such discretionary judgment on the plan administrator, judicial review

of eligibility determinations made by the administrator is limited to the "abuse of discretion" standard. Cathey v. Dow Chemical Co. Medical Care Program, 907 F.2d 554, 558 (5th Cir. 1990), cert. denied, 111 S.Ct. 964 (1991). In this case, the Plan does not confer discretionary authority, and this Court should review plan interpretations *de novo*.

4. However, in reviewing factual determinations made under ERISA plans in claim denials, an abuse of discretion standard is applied. In reviewing factual determinations made by a plan administrator, the Court should give due deference to the factual determinations that reflect a reasonable and impartial judgment. *Pierre v. Connecticut General Life Ins. Co.*, 932 F.2d 1552, 1562 (5th Cir.),

cert. denied, 112 S. Ct. 453 (1991).

5. The plan's definition of total disability is unambiguous as a matter of law.

6. Based upon the evidence before the Plan Administrator on February 2, 1990, the finding that the Plaintiff was not totally disabled was not arbitrary, made without rational basis, nor clearly erroneous. Such factual determination did not constitute an abuse of discretion.

7. All relief sought by Plaintiff should be DENIED.

8. All costs should be paid by the party incurring the same. It is so ORDERED.

Signed the 6th day of January. 1993.

/s/ Paul Brown
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

HERMAN E. MITCHELL, Plaintiff	X	
V.	X	4:90CV125
METROPOLITAN LIFE INSURANCE COMPANY and ALLSTATE LIFE INSURANCE COMPANY Defendants.	X	

ORDER

Pending before the Court is Plaintiff's Motion for New Trial or to Amend Findings and Judgment. The Court, having considered the same, is of the opinion that it should be DENIED.

Plaintiff, Herman Mitchell, raises a variety of arguments in support for his motion. In the first part of his motion, plaintiff presents a laundry list of 38 points of error that he contends requires a new trial or an

amendment of the findings of fact and conclusions of law previously entered by this court. The Court has reviewed these points and concludes that they are without merit.

In the second part of his motion, plaintiff contends that this Court erred in applying the abuse of discretion standard for factual determinations of a plan administrator as set out in *Pierre v. Connecticut General Life Ins. Co.*, 932 F.2d 1552, 1562 (5th Cir. 1991), *cert. denied*, 112 S. Ct. 453 (1991). Plaintiff contends that the Fifth Circuit misinterpreted the Supreme Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. 948 (1989) and that therefore this Court should not interpret Pierre to alter the "*de novo*" standard set forth in Bruch. However, this Court must

faithfully apply Fifth Circuit applicable precedent.[1] This point is without merit.

Third, plaintiffs contend that this Court erred in not looking outside of the record that was before the plan administrator. Plaintiff argues that *Wildbur v. ARCO Chemical Co.*, 974 F.2d 631, 643-645 (5th Cir. 1992), authorizes a district court to examine evidence outside of evidence before a plan administrator. However, the discussion in Wildbur as to considering evidence outside the administrative record occurred within the two-step framework for applying the abuse of discretion standard. Id. at 637-39. However, because the plan administrator

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[1]Assuming *arguendo* that the proper standard of review is "*de novo*," this Court would still find that the plan

applied the correct legal standard in this case under the first prong of the test, this Court need not consider whether it would be appropriate to look outside the administrative record to determine whether the administrator abused his discretion. Id. at 638 (citing three factors that are important in abuse of discretion analysis).[2]

Fourth, plaintiff claims that this Court improperly dismissed his claim for misrepresentation in the sale of an insurance policy under Article 21.21 of

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administrator made the proper factual findings in concluding that plaintiff was not "totally disabled" under the plan.

[2]The issue in this case is whether plaintiff "is completely and continuously unable to do each of the material duties of his job" under the plan.

the Texas Insurance Code.[3] Plaintiff contends that Allstate misled and defrauded his employer, Herring Marathon Group, when it changed its existing policy from Kemper Insurance to Allstate. At the time that Herring Marathon Group Inc. purchased the policy from Allstate, Plaintiff was in charge of procuring such a policy for his employer. According to the plaintiff, he was told that he was purchasing an "own occupation" policy that allegedly provided benefits if the plaintiff was unable to perform "any" of the material duties of his occupation.[4] Plaintiff also contends

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[3]At trial, the Court announced that all state claims had been dismissed.

[4]See Mitchell affidavit in response tc Defendant's Motion for Summary Judgment, pp. 2-3.

that this alleged misrepresentation was verified by letter dated March 14, 1988 from his insurance agent, J. Brock O'Leary, to the plaintiff. However, the O'Leary letter that plaintiff alludes to merely states that the Allstate coverage is for own occupation disability coverage and does not speak to the issue of whether the definition of "disability" is "each" material job duty or "any" material job duty. Furthermore, another O'Leary letter, dated April 4, 1988 and addressed to Jerry Mayo of Herring Marathon Group, clearly defines total disability as "any injury or sickness which prevents insureds from doing each of the material job duties of their occupation." At the top of this letter is written the notation "sent to all officers." Moreover, Allstate's group

long-term disability proposal, specifically tailored for the Herring Marathon Group and attached to O'Leary's first affidavit, clearly defines "total disability" in terms of inability to perform each of the material job duties and not "any" of the material job duties. Furthermore, plaintiff also submitted other evidence that contradicts his own contention. For instance, plaintiff submitted Affidavit Number 2 of J. Brock O'Leary in response to Defendant's Motion for Summary Judgment. O'Leary's affidavit states that based on representations made by Allstate to him, he represented to Herring Marathon Group that if an officer was unable to perform each of the material and substantial duties of his occupation, he would be entitled to disability benefits. Therefore,

plaintiff has contradicted the very assertion that is at the heart of his claim for fraud in the sale of an insurance policy.[5] Therefore, this Court properly dismissed plaintiff's claim for fraud in the sale of an insurance policy under § 21.21 of the Texas Insurance Code for lack of a material fact issue under Rule 56

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[5]Even if it was not fully apparent by the summary judgment evidence submitted by the plaintiff himself that a material fact issue does not exist as to plaintiff's fraud claim, plaintiff's claim should still be dismissed for failure to state a claim upon which relief can be granted under Rule 12 (b)(6). Plaintiff's first amended complaint fails to allege that plaintiff or his employer relied on Allstate's alleged misrepresentations in purchasing the policy. Furthermore, plaintiff's fraud claim does not meet the pleading requirements of Rule 9(b).

before trial.[6]

Fifth, plaintiff contends that the plan's definition of "total disability" is ambiguous because the word "each," as used in the relevant passage of the plan, means "any" and not "each." This Court concludes that the plain meaning of "each" is self-explanatory and that plaintiff's interpretation is incorrect.

Sixth, plaintiff contends that the limitation of the evidence presented at trial rose to the level of a substantive and procedural due process

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[6]Plaintiff properly points out that while plaintiff's claim for breach of contract and improper processing of the claim are preempted under ERISA, *Pilot Life Ins. v. Dedeaux*, 107 S. Ct. 1549 (1987), plaintiff's claim for fraud in the sale of an insurance policy is not preempted under ERISA. See Perkins v. Time Ins. Co., 898 F.2d 470 (5th Cir. 1990).

deprivation. This argument is also without merit.

Plaintiff's motion is thus DENIED.

IT IS SO ORDERED.

Signed this 27th day of May, 1993.

/s/ Paul Brown
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 93-4991

HERMAN E. MITCHELL,

Plaintiff-Appellant,

VERSUS

ALLSTATE LIFE INSURANCE COMPANY, et al.,

Defendants-Appellees.

Appeal from the United States District Court for the Eastern District of Louisiana

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(4:90-CV-125)

Before WOOD*, SMITH, DUHE, Circuit Judges.

PER CURIAM:**

We have reviewed the record and

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*Circuit Judge of the Seventh Circuit, sitting by designation.

**Local Rule 47.5.1 provides:

the briefs on appeal and have heard the arguments of counsel. We find no reversible error on the part of the district court. Its judgment, accordingly, is AFFIRMED.

"The publication of opinions that have no precedential value and merely decide particular cases on the basis of well-settled principles of law imposes needless expense on the public and burdens on the legal profession ." Pursuant to that rule, the court has determined that this opinion should not be published.

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

HERMAN E. MITCHELL Plaintiff,	X X X	
V.	X X	CAUSE NO. CAS-90-125-CA
METROPOLITAN LIFE INSURANCE COMPANY and ALLSTATE LIFE INSURANCE COMPANY, NORTHBROOK, ILLINOIS Defendants.	X X X X X X X	

AFFIDAVIT OF LOUIS A. SHIRLEY, M.D.

STATE OF TEXAS X

COUNTY OF DALLAS X

BEFORE ME, the undersigned authority, on this day personally appeared Louis A. Shirley, M.D. who is personally known to me, and first being duly sworn according to law, upon his oath deposed and said:

"My name is Louis A. Shirley, I am over 18 years of age, of sound mind and

fully competent to make this Affidavit. I have personal knowledge of each of the facts stated therein, and they are all true and correct.

1. I am a medical doctor practicing in the area of Dallas County.

2. My education consists of a medical degree from the University of Mississippi.

3. Additional training, including formal courses, that I have, include an internship at Wilford Hall Hospital and a residency at Fitzsimons Army Hospital.

4. Special licenses that I have include board certification in ophthalmology.

5. Professional associations that I belong to include the American Medical Association and the Texas

Medical Association.

6. Experience in practicing medicine that I have includes practicing medicine in the Air Force from 1959-1976 and in private practice from 1976 to present.

7. I have practiced medicine for 30 years.

8. In practicing medicine I treated and/or examined over 50,000 patients.

9. I have examined Herman E. Mitchell for injury to his eyes. The content of the examinations is included in various documentation that make up my file on this patient. The opinions contained in this Affidavit are based on my examination of Herman E. Mitchell and my file on Herman E. Mitchell and the assumptions contained in item 10 below.

10. Assuming: (a) a definition of disability as follows: "Total disability or totally disabled means the employee is completely and continuously unable to do each of the material duties of his job; and requires the regular care and attendance of a Physician"; and, (b) the material duties of an employee's job are: (i) reading detailed financial records; (ii) reading detailed business documentation; (iii) performing those primary functions and responsibilities described in exhibit "A" attached hereto and incorporated herein by reference the same as if fully copied and set forth at length; (iv) performing secondary responsibilities (to those set forth in exhibit "A"); (v) performing specific elements to each general descriptions

set forth in exhibit "A"; (vi) included performing duties that required visual concentration, including but not limited to reading, reviewing and comprehending complex sales and acquisition documentation relating to commercial real estate transactions, I have the following opinion set forth in items 11 and 12 below.

11. Based on the above and in full support of Dr. Dwain G. Fuller's evaluation and diagnosis of the niacin maculopathy, in my opinion Herman E. Mitchell has suffered permanent damages to his eyes. Supporting the forgoing in layman's terms, the niacin that Herman E. Mitchell used caused blisters on the inside of Herman E. Mitchell's eyeballs, and when these blisters healed permanent scar tissue remained on the inside of Herman E. Mitchell's

eyeballs, thereby causing certain symptoms that Herman E. Mitchell now suffers from.

12. Based on the definition of disability contained in item 10 above and the material employee duties contained in item 10 above, in my opinion Herman E. Mitchell is disabled from doing each of the material duties set forth in item 10 above. It is not my opinion that Herman E. Mitchell is disabled from performing the material duties of <u>any</u> occupation, but it is my opinion that Herman E. Mitchell is disabled from his own occupation as set forth in this affidavit.

/s/ Louis A. Shirley, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME

this 18 day of March, 1991.

My Commission Expires:
10-14-93

/s/ Jacqueline Renee Pinkston
Notary Public in and for the
State of Texas

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

HERMAN E. MITCHELL Plaintiff,	X X X	
V.	X X	CAUSE NO. CAS-90-125-CA
METROPOLITAN LIFE INSURANCE COMPANY and ALLSTATE LIFE INSURANCE COMPANY, NORTHBROOK, ILLINOIS Defendants.	X X X X X X	

AFFIDAVIT OF KELLER P. GREENFIELD, M.D.

STATE OF TEXAS X

COUNTY OF DALLAS X

BEFORE ME, the undersigned authority, on this day personally appeared Keller P. Greenfield, M.D. who is personally known to me, and first being duly sworn according to law, upon his oath deposed and said:

"My name is Keller P. Greenfield, I am over 18 years of age, of sound

mind and fully competent to make this Affidavit. I have personal knowledge of each of the facts stated therein, and they are all true and correct.

1. I am a medical doctor practicing in the area of preventive medicine.

2. My education consists of Bachelor of Science degree from Baylor University, and an M.D. (medical doctor's) degree from Baylor Medical College.

3. Additional training, including formal courses, that I have, include one year general rotating internship at Hermann Hospital in Houston, Texas.

4. Professional associations that I belong to include the American Medical Association, the Texas Medical Association, and the Dallas County Medical Society.

5. Experience in practicing medicine that I have includes 23 years in general and family practice and 14 years in preventive medicine.

7. I have practiced medicine for 37 years.

8. In practicing medicine I treated and/or examined approximately 10,000 to 20,000 patients.

9. I have examined Herman E. Mitchell for injury to his eyes. The content of the examinations is included in various documentation that make up my file on this patient. My file is further supplemented by that certain letter dated march 4, 1991, a copy of which is attached hereto as Exhibit "B" and incorporated herein as if fully set forth at length. The opinions contained in this Affidavit are based on my examination of Herman E. mitchell

and my file on Herman E. Mitchell and the assumptions contained in item 10 below.

10. Assuming: (a) a definition of disability as follows: "Total disability or totally disabled means the employee is completely and continuously unable to do each of the material duties of his job; and requires the regular care and attendance of a Physician"; and, (b) the material duties of an employee's job are: (i) reading detailed financial records; (ii) reading detailed business documentation; (iii) performing those primary functions and responsibilities described in exhibit "A" attached hereto and incorporated herein by reference the same as if fully copied and set forth at length; (iv) performing secondary

responsibilities (to those set forth in exhibit "A"); (v) performing specific elements to each general descriptions set forth in exhibit "A"; (vi) included performing duties that required visual concentration, including but not limited to reading, reviewing and comprehending complex sales and acquisition documentation relating to commercial real estate transactions, I have the following opinion set forth in items 11 and 12 below.

11. Based on Dr. Dwain G. Fuller's report, a copy of which is in my file, it is my opinion that Herman E. Mitchell has suffered permanent damage to his eyes. Supporting the forgoing opinion in layman's terms, the niacin that Herman E. Mitchell used caused blisters on the inside of Herman E. Mitchell's eyeballs, and when these

blisters healed permanent scar tissue remained on the inside of Herman E. Mitchell's eyeballs, thereby causing certain symptoms that Herman E. Mitchell now suffers from.

12. Based on the definition of disability contained in item 10 above and the material employee duties contained in item 10 above, in my opinion Herman E. Mitchell is disabled from doing each of the material duties set forth in item 10 above. It is not my opinion that Herman E. Mitchell is disabled from performing the material duties of <u>any</u> occupation, but it is my opinion that Herman E. Mitchell is disabled from his own occupation as forth in this affidavit.

/s/ Keller P. Greenfield, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME

this 15 day of March, 1991.

My Commission Expires:
02-22-94

/s/ J. Seamster
Notary Public in and for
the State of Texas